DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED R 11/18/2011	
		15G732					
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1730 OSAGE DR KOKOMO, IN 46902			0/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	FIX (EACH CORRECTIVE ACTION S		ULD BE	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS		{W (000}			
	This survey was a post recertification revisit to a fundamental recertification and state licensure survey completed August 31, 2011.						
	Dates of Survey: November 17 and 18, 2011 Facility number: 011266						
	Provider number: 18 AIM number: 20084	5G732					
	Surveyor: Tracy Brumbaugh, Medical Surveyor III						
	compliance with 42 (460 IAC 9 in regard	s Inc. was found to be in CFR, Part 483, Subpart I, and to the post certification cation and state licensure					
	Quality Review com Shebel, Medical Sur	pleted on 12/2/11 by Tim veyor III.					
LABORATORY	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUR	F		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.